

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED OCT 18 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 34720

Registrar's No. 8705

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Smith, RALPH W ALDO

3. (b) If veteran,

name war No

3. (c) Social Security No.

Unknown

4. Sex Male

5. Color or
race White

6. (a) Single, widowed, married,
divorced Widowed

6. (b) Name of husband or wife

May Smith

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

(Month)

(Day)

(Year)

1879

8. AGE:

Years

Months

Days

If less than one day

abt 69

hr. min.

9. Birthplace

Ashley

Illinois

(City, town, or county)

(State or foreign country)

10. Usual occupation

Retired Motorman

11. Industry or business

12. Name Harry Smith

13. Birthplace Albion

Illinois

(City, town, or county)

(State or foreign country)

14. Maiden name Flora M. Post

15. Birthplace Syracuse

New York

(City, town, or county)

(State or foreign country)

16. (a) Informant John E. Smith

(b) Address 615 North Euclid Avenue.,

17. (a) Removal

(b) Date thereof 10/7/48

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation Albion, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.,

19. (a) OCT 6 1948

(b) J. B. Lasater

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 615 North Euclid Avenue.,
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5
year 48 hour 5/30 minute _____ P.M.

21. I hereby certify that I attended the deceased from
Oct 1, 1948 to Oct 5, 1948
that I last saw him alive on Oct 5, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral
vascular accident

Duration

5 days.

Due to Arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) Means of injury _____

23. Signature Shaden V. Elliott (M. D. or other) _____

Address Barnes Hospital, Date signed 10-5-48

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Elton R. H. Remelina
Licensed Embalmer No. 4283
P. O. Address St. Louis, mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.